THE COMMITTEE ON ENERGY AND COMMERCE

INTERNAL MEMORANDUM

July 16, 2012

To: Republican Health Subcommittee Members

From: Health Team

Re: Hearing on: "Using Innovation to Reform Medicare Physician Payment"

On July 18, 2012, at 10:00 a.m. in room 2322 of the Rayburn House Office Building the Subcommittee on Health will be holding a hearing entitled "Using Innovation to Reform Medicare Physician Payment."

I. WITNESSES

Mr. Scott Serota
President and Chief Executive Officer
Blue Cross and Blue Shield Association

Dr. Bruce Nash
Senior Vice President, Medical Affairs; Chief Medical Officer
Capital District Physicians' Health Plan

Dr. David L. Bronson
President
American College of Physicians

Dr. David Hoyt
Executive Director
American College of Surgeons

Dr. Kavita Patel
Managing Director for Clinical Transformation and Delivery
Engelberg Center for Health Care Reform
The Brookings Institution

II. BACKGROUND

Since its implementation in 1966, the Medicare program has struggled to find the proper system to pay providers that would preserve access to care for Medicare beneficiaries and not

lead to growth in Medicare spending that is unsustainable. A number of people have argued that efforts to find an appropriate physician payment system in Medicare have been largely unsuccessful.[1] Currently, providers in the Medicare program face fee cuts estimated at 27.5 percent[2] in January 2013 and the cost of repealing the Sustainable Growth Rate (SGR) formula has been estimated at $316 billion.[3]

In addition to the huge cost of repealing SGR, there is the difficult problem of finding the proper payment and delivery method or methods that will not lead to a repeat of the problems that the Medicare system currently faces.

Previous Attempts to Reform Medicare Physician Payment

CPR. When Medicare was implemented in 1966, providers were paid according to the Customary, Prevailing, Reasonable (CPR) system. The incentives in this payment system led to rapid increases in both the price and volume of services.

Medicare Economic Index: By the mid-1970s, in an attempt to limit costs, prevailing fees were linked to the Medicare Economic Index (MEI), a measure that was supposed to reflect changes in the medical marketplace, including practice costs. The MEI methodology, implemented in 1975, limited charge inflation but placed no control on the volume of services that physicians deliver.

The 1989 Physician Payment Reform: In the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress created a new system based on the resource-based relative value scale (RBRVS) for Medicare physician payments. This legislation also included limits on the right of physicians to balance-bill. The RBRVS system attempted to link physician payment to the resources, or "inputs," that were used in providing medical services. In an attempt to control total spending for physician services driven by volume increases, OBRA also tied the annual update of the fee schedule to the trend in total spending for physicians' services relative to a target that was based on historical trends in volume. This method, effective in 1992, became known as the Medicare Volume Performance Standard (VPS). This system led to unstable and unpredictable physician payment updates.

Sustainable Growth Rate: In 1997, the Balanced Budget Act (BBA) replaced VPS with the Sustainable Growth Rate (SGR) system. Unlike the VPS, the SGR target is tied to growth in the nation's gross domestic product per capita and adjusts physician payments by a factor that reflects cumulative spending relative to the target. While the SGR targets are not limits on expenditures, they represent a "sustainable" trajectory for cumulative spending on Medicare physician services from April 1996 forward.

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[1]Bruce C. Vladeck, Ph.D. Fixing Medicare's Physician Payment System *N Engl J Med* 2010; 362:1955-1957May 27, 2010; also, Reforming Medicare's Physician Payment System, Gail R. Wilensky, Ph.D., N Engl J Med 2009; 360:653-655February 12, 2009.

[2]Medicare Payment Advisory Commission, Report to the Congress, Medicare and the Health Care Delivery System, available at: http://medpac.gov/documents/Jun12_EntireReport.pdf.

[3]Congressional Budget Office: The Budget and Economic Outlook: Fiscal Years 2012 to 2022; pg. 56; available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/01-31-2012_Outlook.pdf.

Medicare payments for Part B services provided by physicians and certain non-physician practitioners are currently made on the basis of a fee schedule, a list of over 7,000 tasks and services for which physicians bill Medicare. The annual update to the conversion factor calculation for physician fees is based on (1) the Medicare Economic Index (MEI), which measures the weighted average annual price changes in the inputs needed to produce physician services; (2) the Update Adjustment Factor (UAF), used to equate actual and target (allowed) expenditures; and (3) allowed expenditures, equal to the actual expenditures updated by the SGR.

Legislative Actions: Each year since 2002, the statutory method for determining the annual updates to the Medicare physician fee schedule, the SGR system, has resulted in a reduction in the reimbursement rates (or a "negative update"). With the exception of 2002, when a 4.8 percent decrease was applied, Congress has passed a series of bills to override the reductions.

The budgetary effect of legislative actions: First, Federal spending for Medicare Part B benefits grew more than it would have otherwise. Second, because the legislation specified that increases in the payment rates should not be considered a change in law or regulation for purposes of determining the expenditure target, the gap between cumulative spending and the cumulative target became larger than it would have been otherwise. In January 2013, under current law, physicians face a 27 percent reduction in the conversion factor for the fee schedule update.

Payment Reform: Spending on physician services continues to rise. In 2010, fee-for service (FFS) Medicare spent about $62 billion under the physician fee schedule on physician and other health professional services, accounting for 12 percent of total Medicare spending and 18 percent of Medicare's FFS spending.[4]

Reform of the Medicare physician payment system will need to go beyond merely refurbishing the current fee schedule and will need to incorporate payment and delivery models that promote the provision of patient-centered care that pays for overall desired outcomes rather than the number and intensity of individual services. Some have argued that the ideal future payment system should permit the maximum amount of choice and physicians should be able to choose how they practice and patients should be able to choose their doctor, actively participate in their health care decisions and, where appropriate, choose the setting in which they receive care.

When reforming Medicare physician payments, two issues must be addressed:

Budgetary: Currently, merely to wipe out the accumulated debt so far and restart from the baseline, close to $300 billion in offsets would need to be identified.

Policy: The current system for reimbursing providers in Part B rewards physicians for the volume of services they provide, not the value of the services or medical outcomes, and simply rebasing the current SGR will not alter those incentives. In determining the optimal method for

[4]Report to the Congress, Medicare Payment Policy, Medicare Payment Advisory Commission, March, 2012, available at: http://www.medpac.gov/documents/Mar12_EntireReport.pdf.
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reimbursing physicians in Medicare going forward, solutions should preserve access to services while also ensuring the program does not incentivize excessive spending.

III. **ISSUES**

Although a number of innovative arrangements between payers and providers are currently underway in the private sector, this is generally not the case in the Medicare program. This hearing will explore possible options for how Medicare can use innovative ideas and payment/delivery models from the private sector to reform the current physician payment system.

IV. **STAFF CONTACTS**

If you have any questions regarding the hearing, please contact John O'Shea or Ryan Long at (202) 225-2927.